

**MSI Medica Choice Passport ASO 1500-20% CMM
BENEFIT SUMMARY**

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Partial listing of covered services	Your cost if you visit a:	
	In-Network provider	Out-of-Network provider
Annual Deductible <i>The amount paid per year before the health plan starts to pay.</i>	\$1,500 per member \$3,000 per family	\$2,500 per member \$5,000 per family
Annual Out-of-Pocket Maximum <i>The most you pay in a year for health care services covered by your insurance.</i>	\$2,500 per member \$5,000 per family Pharmacy limit of \$1,000 per person/ \$2,000 per family combined in-network and out-of-network.	\$4,000 per member \$8,000 per family Pharmacy limit of \$1,000 per person/ \$2,000 per family combined in-network and out-of-network.
Office visits <ul style="list-style-type: none"> ● Primary care ● Specialist visits ● Chiropractic care ● Convenience/Virtual care 	20% coinsurance 20% coinsurance 20% coinsurance 20% coinsurance	20% coinsurance 20% coinsurance 20% coinsurance 20% coinsurance <i>Chiropractic care is limited to 15 visits per member per year out-of-network.</i>
Preventive care <ul style="list-style-type: none"> ● Routine Physical & Eye Exams ● Immunizations & Cancer Screenings ● Well Child Care 	No charge No charge No charge	Well child care: 0% coinsurance. <i>The deductible does not apply.</i> Other services: 0% coinsurance
Lab and Pathology	20% coinsurance	20% coinsurance
X-Ray and Other Imaging <ul style="list-style-type: none"> ● X-rays ● CT, MRI, PET scans 	20% coinsurance 20% coinsurance	20% coinsurance 20% coinsurance
Prescription Drugs <i>Up to a 31-day supply per prescription.</i>	<i>The deductible does not apply.</i> Generic: \$20 copay/prescription Mail order: \$40 copay/prescription Preferred brand: \$20 copay/prescription Mail order: \$40 copay/ prescription Non-preferred brand: \$75 copay/prescription Mail order: \$150 copay/prescription	40% coinsurance <i>The deductible does not apply.</i>
Specialty Prescription Drugs <i>Up to a 31-day supply per prescription received from a designated specialty pharmacy.</i>	<i>The deductible does not apply.</i> Preferred: 20% coinsurance. No more than \$300 copay/ prescription. Non-Preferred: 40% coinsurance	Not covered
Outpatient Hospital Services <ul style="list-style-type: none"> ● Facility ● Physician/surgeon fees 	20% coinsurance 20% coinsurance	20% coinsurance 20% coinsurance

Emergency Services <ul style="list-style-type: none"> ● Emergency room services ● Emergency medical transportation ● Urgent care 	20% coinsurance 20% coinsurance 20% coinsurance	20% coinsurance 20% coinsurance 20% coinsurance
Inpatient Hospital Services <ul style="list-style-type: none"> ● Facility ● Physician 	20% coinsurance 20% coinsurance	20% coinsurance 20% coinsurance
Behavioral Health/Mental Health & Substance Abuse Care <ul style="list-style-type: none"> ● Outpatient services ● Inpatient hospital services 	20% coinsurance 20% coinsurance	20% coinsurance 20% coinsurance
Maternity Benefits <ul style="list-style-type: none"> ● Prenatal care ● Postnatal care ● Delivery & inpatient services 	No charge No charge 20% coinsurance	Prenatal: 0% coinsurance <i>The deductible does not apply.</i> 20% coinsurance 20% coinsurance
Durable Medical Equipment & Prosthetics	20% coinsurance	20% coinsurance

This health care plan is administered by Medica Self Insured (MSI). It may not cover all your health care expenses; read your Plan Document carefully to determine which expenses are covered. This is a benefit summary only and does not outline all of your benefits. If there is a discrepancy between information in this summary and your Plan Document, the Plan Document will take precedence in determining your benefits.

This is a high level summary and does not replace your Summary of Benefits and Coverage. Please contact Medica at 1-800-952-3455 to obtain further benefit information.

COM Northfield Public Schools ISD
659-BS-1-00121

Discrimination is Against the Law

Medica complies with applicable Federal civil rights laws and will not discriminate against any person on the basis of race, color, national origin, age, disability or sex. Medica:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as: TTY communication and written information in other formats (large print, audio, other formats).
- Provides free language services to people whose primary language is not English, such as: Qualified interpreters and information written in other languages.

If you need these services, call the number included in this document or on the back of your Medica ID card. If you believe that Medica has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with: Civil Rights Coordinator, Mail Route CP250, PO Box 9310, Minneapolis, MN 55443-9310, 952-992-3422 (phone/fax), TTY 711, civilrightscordinator@medica.com.

You can file a grievance in person or by mail, fax, or email. You may also contact the Civil Rights Coordinator if you need assistance with filing a complaint.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf> or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201, 800-368-1019, 800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

If you want free help translating this information, call the number included in this document or on the back of your Medica ID card.

Si desea asistencia gratuita para traducir esta información, llame al número que figura en este documento o en la parte posterior de su tarjeta de identificación de Medica.

Yog koj xav tau kev pab dawb kom txhais daim ntwav no, hu rau tus xov tooj nyob hauv daim ntwav no los yog nyob nraum qab ntwam koj daim npav Medica ID.

如果您需要免費翻譯此資訊，請致電本文檔中或者在您的Medica ID卡背面包含的號碼。

Nếu quý vị muốn trợ giúp dịch thông tin này miễn phí, hãy gọi vào số có trong tài liệu này hoặc ở mặt sau thẻ ID Medica của quý vị.

Odeeffannoo kana gargaarsa tolaan akka isinii hiikamu yoo barbaaddan, lakkoobsa barruu kana keessatti argamu ykn ka dugda kaardii Waraqaa Eenyummaa Medica irra jiruun bilbila'a.

إذا كنت تريد مساعدة مجانية في ترجمة هذه المعلومات، فاتصل على الرقم الوارد في هذه الوثيقة أو على ظهر بطاقة تعريف ميديكا الخاصة بك.

Если Вы хотите получить бесплатную помощь в переводе этой информации, позвоните по номеру телефона, указанному в данном документе и на обратной стороне Вашей идентификационной карты Medica.

ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປຂໍ້ມູນນີ້ຟຣີ, ໃຫ້ໂທຫາເລກໝາຍທີ່ມີຢູ່ໃນເອກະສານນີ້ ຫຼື ຢູ່ດ້ານຫຼັງຂອງບັດ Medica ຂອງທ່ານ.

이 정보를 번역하는 데 무료로 도움을 받고 싶으시면, 이 문서에 포함된 전화번호나 Medica ID 카드 뒷면의 전화번호로 전화하십시오.

Si vous voulez une assistance gratuite pour traduire ces informations, appelez le numéro indiqué dans ce document ou au dos de votre carte d'identification Medica.

နမ့်အဲဒီတော်ကိစ္စထဲစာကလီနစ်နာတော်ကိစ္စအလဲအလှယ်အကလီနစ်ကိစ္စလီတဲမိန့်ဂ်လဲအပုဂ်
ယုဂ်လဲလဲတီလဲလဲအပုဂ်အဲဒါမုတမုါဖဲနနုနီငခေလဲအုဂ်သးခးကုအလီခဲတကယအမိန့်ဂ်တက့.

Kung nais mo ng libreng tulong sa pagsasalin ng impormasyong ito, tawagan ang numero na kasama sa dokumentong ito o sa likod ng iyong Kard ng Medica ID.

ይህን መረጃ ለመተርጎም ነጻ እርዳታ የሚገልግል ከሆነ በዝነ ህ ሰነድ ወሰጥ ያለውን ቁጥር ወይም Medica መታወቂያ ካርድዎ በስተጀርባ ያለውን ደደውሉ።

Ako želite besplatnu pomoć za prijevod ovih informacija, nazovite broj naveden u ovom dokumentu ili na poleđini svoje ID kartice Medica.

Dii t'áá jiiik'e shá ata' hodoonih níimízingo éi ninaaltsoos Medica bee néiho'dílzinígí bine'décé' námboo biká'ígíjii' b'éesh bee hodílnih.

Wenn Sie bei der Übersetzung dieser Informationen kostenlose Hilfe in Anspruch nehmen möchten, rufen Sie bitte die in diesem Dokument oder auf der Rückseite Ihrer Medica-ID-Karte angegebene Nummer an.